DOCUMENT RESUME

ED 296 250 CG 020 942

AUTHOR	Fredisdorf, Mark
TITLE	Alcohol and Other Drug Program School Grant Study. Bulletin No. 8343.
INSTITUTION	Wisconsin State Dept. of Public Instruction, Madison. Bureau for Pupil Services.
PUB DATE	87
NOTE	64p.
PUB TYPE	Reports - Research/Technical (143)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Alcohol Abuse; *Alcohol Education; Drug Abuse; *Drug Education; *Elementary Secondary Education; Grants; *Intervention; *Prevention; *Program Effectiveness; School Community Relationship; State Boards of Education
IDENTIFIERS	Wisconsin

ABSTRACT

A Wisconsin program which provided grants to schools for projects that addressed prevention and intervention services for alcohol and other drugs was examined. A survey of fully implemented programs yielded 81 usable prevention and 47 usable intervention questionnaires. Results showed that the school grant program had served as an effective catalyst for motivating schools to develop and implement drug and alcohol prevention programs. Most school districts had maintained and often expanded their efforts in years subsequent to receiving funds. School programs were predominantly school-based and did not systematically involve community members or agencies. Project directors generally viewed existing school-based programs as effective in addressing drug and alcohol problems. However, there was a perceived need to go beyond the current level of effort to provide comprehensive services to all grade levels. Many schools had a shortage of properly trained personnel. The greatest obstacles to providing effective prevention and intervention services were high rates of alcohol and drug use in homes and communities; denial of alcohol and drug abuse problems among students, parents, and other community members; and lack of staff time for prevention and intervention activities. Project directors indicated a need for schools to initiate greater involvement of parents, non-school alcohol and drug agencies, and other community organizations in school activities. (ABL)

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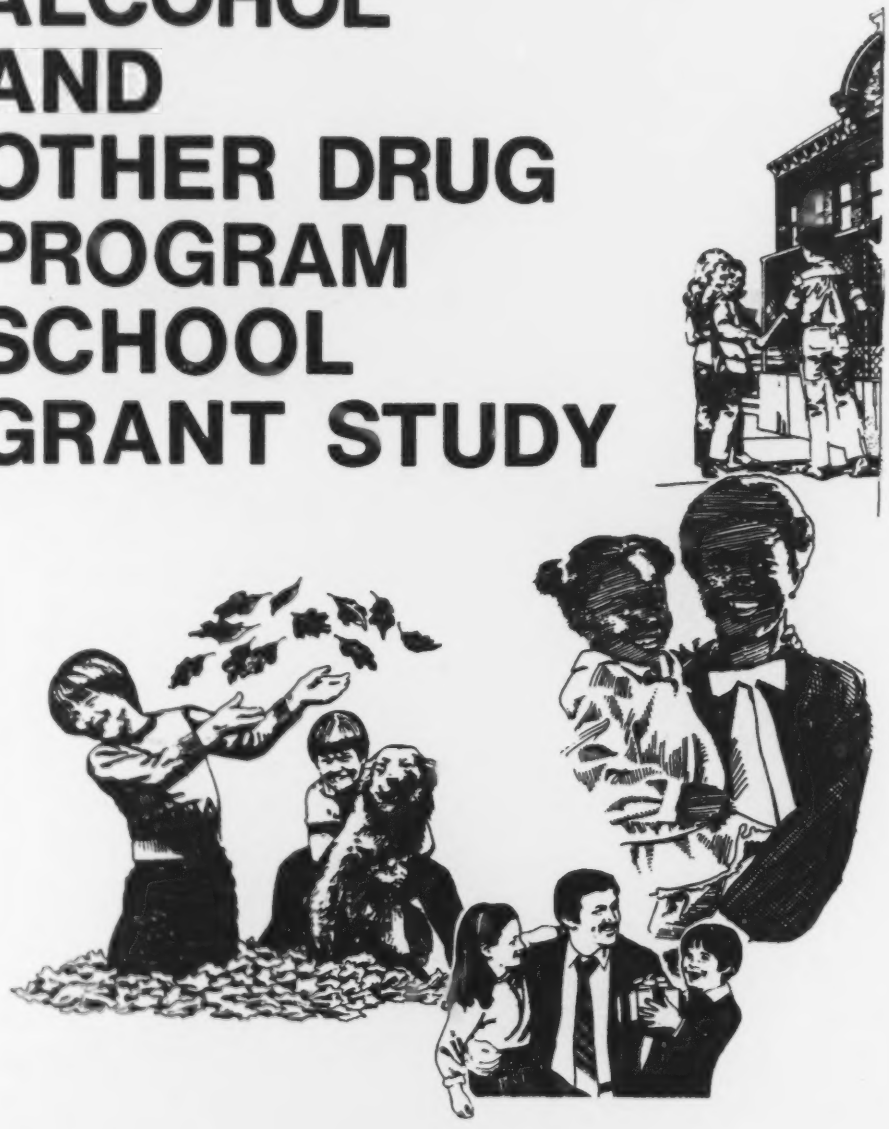

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Alcohol and Other Drug Program School Grant Study

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Bulletin No. 8343

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Acknowledgements

The Alcohol and Other Drug Program School Grant Study is the result of extensive collaborative efforts by Department of Public Instruction staff, local school district practitioners and University of Wisconsin-Madison research experts.

Dr. William Richards and Susan Fredlund of the department provided extensive assistance throughout the study.

Editorial assistance was provided by Bureau for Education Information Services, and Connie Salveson, Bureau for Pupil Services.

Dr. Harry Sharp, Gene Sharp, Jane Niece and Diana Bott of the University of Wisconsin-Madison Survey Research Laboratory conducted the data collection and analysis procedures.

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Introduction

In 1979, the Wisconsin Legislature passed a landmark bill referred to as Chapter 331: The New Juvenile Drinking Law. The legislation included a number of provisions intended to help local law enforcement and local school districts deal with alcohol and other drug (AOD) use. Section 115.36, Wis. Stats., directed the Department of Public Instruction (DPI) to help schools develop comprehensive programs to prevent AOD abuse among young people and assist those who experience problems as a result of such abuse. The legislation directs DPI to help school districts better utilize the staff and program resources they currently have by improving access to AOD-related resources such as training, information, and technical assistance.

A grant program to help fund school initiatives is one of the resources DPI was directed to provide under sec. 115.36(3)(a), Wis. Stats. An excerpt of this subsection is found in Appendix A. The first demonstration grants were awarded for the 1981-82 school year. The primary purpose of the grant program was, and is today, to fund school projects which have the potential to serve as demonstration models for other school districts in the state. Over 160 school districts have received grant funds directly or as members of a consortium. Grants have ranged from $4,756 to $50,000. The average grant award has been approximately $15,000. Grant recipients provide at least a 20 percent matching contribution.

Grants are awarded for projects that address needs along the continuum from prevention efforts to intervention services. A primary distinction is that prevention refers to programs designed to minimize the occurrence of future problems related to AOD use while intervention refers to programs designed to help students who are already experiencing problems.

The following briefly defines AOD program types. Appendices B and C contain more detailed descriptions.

Prevention

Efforts to provide pupils with appropriate information and developmental experiences necessary to make personally and socially responsible decisions regarding their AOD use and nonuse and to cope effectively with the personal and social results of decisions made by others regarding such use. Comprehensive programs include the following AOD-related knowledge or skill components: personal competencies, social competencies, social systems and AOD information.

Intervention

Efforts to provide appropriate assistance to students experiencing personal or social problems resulting directly from a student's AOD use or indirectly from another's use. Comprehensive programs include the following AOD-related service components: identification and assessment; in-school assistance; outside referral; after-care support.

School districts have received grants for prevention programs, intervention programs or both. Of the 159 school districts that have participated in the grant program through the 1986-87 school year, 43 have received funding for intervention programs, 104 for prevention programs, and 12 have received funding for both.

Purpose of the Study

Projects funded through the grant program are intended to serve as models for other school districts in the state. To facilitate this process, sec. 115.36(3)(a), Wis. Stats., directs DPI to monitor implementation, and to assist in and assure evaluation of demonstration projects. In line with this charge, DPI has undertaken this study to assess the status of AOD prevention and intervention efforts of grant recipients. Specifically, the purpose of this study is to address the following questions about school district AOD projects that have received grant funds:

1. What prevention and intervention efforts are being made to reduce AOD-related problems?

2. What AOD prevention and intervention efforts do districts desire to emphasize to a greater degree?

3. What favorable impacts do project directors perceive AOD prevention and intervention efforts to have on students?

4. What favorable impacts do project directors perceive AOD prevention and intervention efforts to have on school staff, parents and community members?

5. What factors inhibit school AOD prevention and intervention efforts?

6. What assistance would be most helpful to school districts to facilitate AOD prevention and intervention efforts?

Data Collection Procedures

Two questionnaires were developed to collect data to address the study questions (Appendix D). One questionnaire focused primarily on prevention efforts and the other on intervention efforts. Development of the survey forms was a result of the combined efforts of DPI staff, local school district AOD project directors, the State Superintendent's AOD Advisory Council, and University of Wisconsin-Madison survey research experts.

To ensure quality control, the Wisconsin Survey Research Laboratory (WSRL) was contracted to conduct the mailing, data entry, and analysis procedures. The questionnaires were mailed by WSRL in November 1986 to all AOD project directors for school districts that had received one or more grants from the 1981-82 to the 1985-86 school years inclusive. Districts that received a grant for the 1986-87 school year only were not included in the study because their projects were not fully in place. The AOD project directors were asked to complete a prevention or an intervention questionnaire depending on the type of project funded by the grant. Project directors of districts that received funding for both types of projects were asked to complete both questionnaires. Project directors were asked to complete a survey questionnaire(s) concerning the AOD project(s) for which grant support was received even though additional AOD efforts may have existed in the district's schools. One hundred and two prevention and 49 intervention questionnaires were mailed. Of these, 81 usable prevention and 47 usable intervention questionnaires were returned. The overall response rate was 85 percent.

Presentation of Findings

The study focuses on both prevention and intervention grant projects. For clarity of presentation, the results are reported separately for each type of project. This is not intended to suggest that prevention and intervention efforts are unrelated. Of the districts surveyed, most address AOD-related problems using a combined prevention-intervention approach.

1. What prevention and intervention efforts are being made to reduce AOD-related problems?

Prevention

Over 70 percent of school districts surveyed have prevention programs in place at the elementary, middle school/junior high, and senior high school levels. A slightly higher emphasis on prevention programs exists at the middle school/junior high level. School staff most closely involved with AOD prevention efforts are counselors, classroom teachers, health education coordinators, school psychologists, and principals. Administrative support and involvement are reported to exist in most school districts. A strong emphasis is placed on training staff prior to having them directly participate in AOD prevention programs. This emphasis often involves providing inservice sessions for all staff members to inform them about the school district's prevention program in addition to training staff who are directly serving students in this capacity.

Nonschool staff participants include parents, law enforcement officials, community AOD agency staff, and school board members. One half of the prevention project respondents reported that at least one parent is actively involved in their programs, although less than 20 percent of the school districts have formed parent/school/community AOD planning or advisory councils.

Prevention efforts consist largely of teacher-AOD instruction. This instruction includes disseminating information to students and parents, teaching peer refusal and decision-making skills, and developing positive student self-concepts. Presentations to students by community professionals or other nonschool staff, and by other students are additional components of many prevention programs. These activities are most likely to take place in elementary school classrooms, health classes, and driver education classes. To a much lesser extent, AOD prevention activities take place in biology, home economics, and social studies classes. Student groups such as *Students Against Driving Drunk (SADD)* exist in less that 25 percent of responding school districts although comments volunteered by project directors indicate that the formation of these groups is increasing rapidly. Five percent of the districts surveyed conduct an AOD prevention "Awareness Week" during which several of the aforementioned activities are emphasized.

There is considerable variation in curricular approaches among grant recipients. Twenty-seven percent use a purchased curriculum, 32 percent use a school developed curriculum and 37 percent use a combination of the two. Four percent of the respondents didn't indicate the curriculum used. The most commonly used purchased curriculum is *Here's Looking At You Two* or *Here's Looking At You 2000* followed closely by the *Cambridge and Sommerville Program For Alcoholism Rehabilitation (CASPAR)*. Other commercially developed curricula used by districts include *Quest, Project Charlie,* and *Starting Early*.

Most school districts inform parents of student participation in AOD prevention programs. Under sec. 118.01(2)(d)(2c), Wis. Stats., school districts are required to provide instruction about the effects of controlled substances and alcohol upon the human system. Parents, however, may exempt their children from such instruction by submitting a written objection to the teacher.

The dissemination of information to parents about AOD prevention is a common practice. This information often includes pamphlets and booklets about actions that parents can take to help prevent AOD use among their children. Actual training sessions and inservices for parents or other community members, however, are not emphasized.

Intervention

Of the 49 school districts receiving the questionnaire, 47 responded. These districts all reported intervention programs currently are in place in their schools. Three-fourths of districts labeled their programs "student assistant programs" (SAPs) and indicated that the primary focus was on AOD-related problems rather than on a wide variety of problems with AOD intervention as a subcomponent. Most districts implemented their programs at the high school level (89 percent) and at the junior high/middle school level (81 percent). AOD intervention programs serving elementary school students exist in one-half of districts surveyed.

School counselors, classroom teachers, principals, and psychologists are school staff members who are most directly involved with AOD intervention programming. School board members, directors of pupil services, district administrators, health education coordinators, school nurses, and social workers are less frequently active in AOD intervention programs across school districts.

One or more parents play an active role in intervention programming in 64 percent of reporting school districts. Community AOD agency staff are directly involved in one-half of such programs. Thirty-nine percent of districts utilize the services of local law enforcement personnel in their programs while 19 percent have established community AOD planning boards or councils.

AOD intervention activities largely involve the formation of support groups for students who have AOD-related problems because of their own use or because of another person's use. Support groups offer students an opportunity to discuss AOD-related issues and to receive assistance from peers and trained school staff on how to solve or cope with problems relating to substance use. Students concerned about the AOD use and/or abuse of others participate in larger numbers overall than students experiencing problems directly because of their own AOD use. Ninety-eight percent of districts have "concerned persons" participating in support groups. Slightly fewer districts (90 percent) have support groups operating for students who are experiencing problems related to personal AOD use. These students may or may not be considered AOD dependent. After-care support groups for students recovering from AOD abuse problems are not emphasized to the degree of the above mentioned groups. About half of the districts reported they have no more than one such student participating in any of their support groups.

Several components of the support group approach to AOD intervention were identified as "important". One component is a well-defined, school board approved AOD policy and procedure statement. Another is administrative support and involvement in the program. It is standard practice for schools to systematically screen students prior to assigning them to support groups. Specific information about screening methods used by school district staff was not collected as part of this study. Access to professional outside

AOD diagnostic services for screening and referral is considered a priority by a majority of districts. Excusing students from class to participate in group sessions is a common practice. Prior to facilitating support groups, staff members undergo initial comprehensive training. This training is most often provided by private agency personnel although a small number of districts have received training assistance from other school district employees or from DPI staff. As part of, or in addition to participation in support groups, students in most districts have available to them individual counseling by teachers, counselors, or other school staff. Dissemination of general AOD information to students and parents is emphasized in most intervention programs.

Peer counseling or peer education practices are not as common in intervention programs as in prevention programs. According to respondents, support group activities do not typically include addressing issues often related to AOD use and/or abuse. For example, out of 25 possible items listed on the survey instrument that may be associated with intervention efforts, suicide prevention and human growth and development education issues ranked among the bottom five in terms of level of emphasis. AOD-related support groups for school employees or parents are also absent from most intervention programs.

Respondents to the prevention and intervention questionnaires were asked to identify all existing school-based efforts and combined school/community based efforts. They were asked to indicate the degree of emphasis that was placed on each program area during the first year of operation, the degree of current emphasis, and the degree of desired emphasis. The average responses of both prevention and intervention project directors on the three scales for all items are presented in Appendix V. In the following table are listed the ten school-based and combined school/community-based prevention and intervention efforts currently emphasized to the greatest degree by grant recipients.

Table 1 The Ten School-Based and Combined School/Community Based AOD Prevention and Intervention Efforts Emphasized to the Greatest Degree

Prevention

School-Based Efforts

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 81

Item	Degree of Current Emphasis
1. Administrative support of prevention program(s)	3.92
2. AOD taught in health education	3.91
3. Dissemination of AOD information to students	3.61
4. Middle school/Junior high AOD instruction	3.57
5. Elementary school AOD instruction	3.54
6. Prevention program includes counseling by school staff	3.39
7. School staff trained prior to teaching AOD	3.31
8. Presentations to students by school staff about AOD prevention	3.19
9. Peer refusal skills are developed	3.16
10. Direct administrative involvement in prevention program(s)	3.13

Combined School/Community-Based Efforts

No. of Respondents = 81

Item	Degree of Current Emphasis
1. Cooperative efforts with public or private community AOD agencies	3.41
2. Dissemination of information to parents about AOD prevention	3.15
3. Parents are informed of student participation in AOD prevention programs	3.14
4. Presentations to students by community professionals or other nonschool staff	3.12
5. Media attention and other efforts to gain community support	2.84
6. Liaison relations and/or agreements with local law enforcement	2.78
7. Cooperative efforts with community AOD supportive groups (e.g., churches, councils, service organizations)	2.77
8. Systematic involvement of parents in AOD prevention efforts	2.68
9. Liaison relations and/or agreements with juvenile court system or Health and Social Services	2.44
10. Training sessions and inservices for community members/parents about AOD use and/or abuse prevention	2.43

Intervention (Table 1 continued)

School-Based Efforts

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 47

Item	Degree of Current Emphasis
1. Support group(s) for concerned persons	4.06
2. Well-defined, Board approved AOD policy and procedure statement	4.00
3. Students excused from class to participate in group sessions	3.94
4. Administrative support of intervention program	3.72
5. Systematic procedures for student referral within school	3.64
6. Support group(s) for AOD use and/or abuse problems	3.63
7. Individual counseling provided by teachers, counselors or other school staff	3.60
8. Systematic procedures for student screening or preassessment	3.57
9. Comprehensive initial training for core group staff members	3.51
10. Dissemination of general AOD information to students	3.47

Combined School/Community-Based Efforts

No. of Respondents = 47

Item	Degree of Current Emphasis
1. Access to professional outside AOD diagnostic services	3.68
2. Cooperative efforts with community or county AOD agencies, councils or organizations (e.g., 51.42 Boards, AOD councils)	3.60
3. Presentations to students by community professionals or outside speakers	3.26
4a. Dissemination of written information to parents about AOD programs	3.23
4b. Cooperative efforts with inpatient treatment agencies	3.23
5. Liaison relations and/or agreements with local law enforcement	2.91
6. Media attention and other efforts to gain community support	2.85
7. Cooperative efforts with community AOD supportive groups (e.g., churches, service organizations)	2.79
8. Systematic involvement of parents in intervention efforts	2.72
9. Liaison relations and/or agreements with juvenile court system or Health and Social Services	2.64
10. Cooperative efforts with community self-help groups (e.g., AA, Alanon, Alateen)	2.45

2. What AOD prevention and intervention efforts do districts desire to emphasize to a greater degree?

This question was asked to determine what actions project directors considered important to improve programs and to identify areas where increased effort might be focused. The following discussion addresses those efforts that project directors expressed the greatest desire to emphasize in their programs. The reader will note that many of the items with high mean scores on the desired emphasis scale (Table 2) also received high mean scores on the current emphasis scale (Table 1).

Prevention

School-Based Efforts. Administrative support of prevention programs received the highest mean score by project directors on the desired emphasis scale. This further substantiates the importance of administrative support to program sustenance and success. Along with administrative support, an increase in elementary school, middle school/junior high school, and senior high school AOD instruction was also strongly supported. Project directors believe emphasized program components should include the dissemination of AOD information to students, the teaching of peer refusal skills, the availability of advisement by school staff, and the creation of peer groups (e.g., "Just Say No" groups). Staff training prior to teaching AOD prevention-related subject matter and the systematic evaluation of AOD prevention programs are two additional activities project directors believe should have more attention.

Combined School/Community-Based Efforts. Project directors expressed a great desire to increase systematic parental involvement in AOD prevention efforts. Detailed information about how parents are, or should be, involved with AOD prevention was not requested from project directors. To bring about positive involvement, respondents felt well-defined procedures were needed to guide parent participation. Cooperative efforts with public or private community agencies also received high support. This strengthens the contention that parental/community involvement fosters school efforts to prevent AOD-related problems. Project directors indicated measures are being taken by school districts to garner outside support for AOD prevention programs, but further initiatives are needed to better utilize available nonschool resources.

Intervention

School-Based Efforts. Support groups for concerned persons received the highest mean score of all 25 items on the intervention survey for current and desired emphasis. High scores on both scales show that this is the primary activity for many programs. Project directors also indicated a strong desire to place greater emphasis on efforts related to support group formulation and functioning. These were systematic procedures for student screening and referral, along with policies that permit students to be excused from class to participate in group sessions. Respondents also expressed a desire to continue emphasizing support groups for students with AOD use and/or abuse related problems. Lesser support was indicated for placing greater emphasis on support groups for students recovering from AOD abuse. It is not clear whether this reflects the relatively small numbers of recovering students reported to exist in most school districts or a lack of commitment to serve these students.

A well-defined, board approved AOD policy and administrative support for intervention program efforts are two related items that project directors reported should receive a high level of emphasis. A large number of respondents made comments about the importance of AOD policy formulation to the effect that a sound policy provides a firm basis for all AOD activities. Another prerequisite to an effective intervention strategy that respondents felt requires greater attention is facilitator training for support groups and creating opportunities to inform all school staff about AOD intervention efforts.

Combined School/Community-Based Efforts. Items receiving the greatest support for increased emphasis were those addressing cooperative efforts with community groups or agencies. Respondents expressed a strong desire to increase cooperative efforts with the following entities: (a) community or county AOD agencies such as 51.42 Boards, (b) local law enforcement agencies, (c) inpatient treatment agencies, (d) AOD supportive groups such as churches and service organizations, (e) agencies that provide AOD diagnostic services, and (f) the juvenile court system or health and social services. There is a pervasive belief among intervention project directors that efforts to effectively serve students with AOD-related problems must go beyond the school setting.

Table 2 The Ten School-Based and Combined School/Community-Based AOD Prevention and Intervention Efforts That Project Directors Desire to Emphasize to the Greatest Degree

Prevention

School-Based Efforts

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 81

Item	Degree of Desired Emphasis
1. Administrative support of prevention program(s)	4.58
2. Elementary school AOD instruction	4.49
3. Middle school/Junior high AOD instruction	4.40
4. AOD taught in health education	4.35
5a. Dissemination of AOD information to students	4.31
5b. School staff trained prior to teaching AOD	4.31
6. High school AOD instruction	4.26
7. Prevention program includes counseling by school staff	4.24
8. Peer refusal skills are developed	4.21
9. Direct administrative involvement in prevention program(s)	4.04
10. Provisions for prevention services are built into athletic policies	4.00

Combined School/Community-Based Efforts
No. of Respondents = 81

Item	Degree of Desired Emphasis
1. Dissemination of information to parents about AOD prevention	4.25
2. Systematic involvement of parents in AOD prevention efforts	4.18
3. Cooperative efforts with public or private community AOD agencies	4.05
4. Parents are informed of student participation in AOD prevention programs	4.03
5. Presentations to students by community professionals or other nonschool staff	3.99
6. Liaison relations and/or agreements with local law enforcement	3.96
7. Media attention and other efforts to gain community support	3.94
8. Cooperative efforts with community AOD supportive groups (e.g., churches, councils, service organizations)	3.91
9. Training sessions and inservices for community members/parents about AOD use and/or abuse prevention	3.81
10. Liaison relations and/or agreements with juvenile court system or Health and Social Services	3.72

Intervention (Table 2 continued)

Combined School/Community-Based Efforts
No. of Respondents = 47

Item	Degree of Desired Emphasis
1. Support group(s) for concerned persons	4.65
2. Students excused from class to participate in group sessions	4.54
3. Systematic procedures for student referral within school	4.53
4. Administrative support of intervention program	4.48
5. Well-defined, Board approved AOD policy and procedure statement	4.45
6. Systematic procedures for student screening or pre-assessment	4.37
7. Support group(s) for AOD use and/or abuse problems	4.33
8a. Dissemination of general AOD information to students	4.26
8b. Comprehensive initial training for core group staff members	4.26
9. Presentations by school staff to students about the school's AOD program	4.17
10a. Individual counseling provided by teachers, counselors or other school staff	4.15
10b. Systematic procedures for student referral outside of school	4.15

School-Based Efforts
Degree of desired emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest
No. of Responsents = 47

Item	Degree of Desired Emphasis
1. Cooperative efforts with community or county AOD agencies, councils or organizations (e.g., 51.42 Boards, AOD councils)	4.57
2. Liaison relations and/or agreement with local law enforcement.	4.24
3. Cooperative efforts with inpatient treatment agencies	4.22
4. Access to professional outside AOD diagnostic services	4.20
5. Dissemination of written information to parents about AOD programs	4.13
6. Cooperative efforts with community AOD supportive groups (e.g., churches, service organizations)	4.00
7. Liaison relations and/or agreements with juvenile court system or Health and Social Services	3.98
8a. Systematic involvement of parents in intervention efforts	3.91
8b. Presentations to students by community professionals or outside speakers	3.91
9. Cooperative efforts with community self-help groups (e.g., AA, Alanon, Alateen)	3.83
10. Media attention and other efforts to gain community support	3.72

3. What favorable impacts do project directors perceive AOD prevention and intervention efforts to have on students?

Prevention

The purpose of this question was to determine how project directors perceive their prevention projects to impact on students at the elementary, middle school/junior high, and senior high levels. Project directors were asked to provide their perceptions of impacts. No request was made of respondents to provide empirical or other evidence to substantiate their perceptions.

The greatest perceived impact across all grade levels was increased student knowledge of AOD use and abuse issues. Other impacts ranked high across all grade levels were: improved emotional/mental health of students, improved relations between students and peers, improved relations between students and school staff, and improved relations between students and their families.

Among elementary school students, project directors perceive prevention efforts to delay the onset of AOD use and/or abuse. Furthermore, these efforts reduce the rate of alcohol, tobacco and, to a lesser extent, marijuana use.

Respondents indicated prevention efforts have less impact on delaying the onset of AOD use and/or abuse when students reach middle school/junior high school age and senior high school age. But, project directors said there was a substantial impact on reducing marijuana, alcohol, and tobacco use among these older students. Other favorable impacts experienced more by middle school/junior high and senior high students than by elementary school students are improved physical health, increased participation in extra-curricular activities, and reduced involvement in traffic accidents. Six districts mentioned improved decision making as a prevalent favorable impact. These respondents did not specify whether they were referring to all students or to a sub-group of students.

Respondents reported prevention efforts as having a small impact on cocaine use. It is unclear whether this reflects a lower level of cocaine use among students compared with alcohol, tobacco, and marijuana use or ineffectiveness of program efforts. Project directors ranked improved attendance and reduced dropout rates lower than most other favorable impacts. Also, AOD prevention efforts are not perceived to have a strong favorable impact on student academic performance.

Intervention

The purpose of this question was to determine project directors' perceptions of intervention program impacts on the total student population and six student subgroups. These subgroups are: (a) users and/or abusers, (b) concerned persons, (c) recovering students, (d) elementary school students, (e) middle school/junior high students, and (f) senior high students. Intervention project directors were asked their perceptions of favorable impacts. They were not requested to provide empirical data or other evidence to substantiate perceptions.

First among favorable impacts perceived for all subgroups was improved emotional/mental health of students followed by improved relations between students and school staff, and improved social functioning between students and peers. Overall, improved school attendance and increased participation in "alternative" social and recreational activities were ranked slightly higher than reduced marijuana and alcohol

use as favorable impacts. Project directors indicated students who participate in AOD intervention programs are more likely to benefit from improved mental health and social functioning than from reduced AOD use and/or abuse. This pattern is particularly evident for concerned persons and elementary school students.

Favorable impacts on recovering students are unique compared to other subgroups. Recovering students benefit more by reduced marijuana and alcohol use than other program participants, but are less likely to experience improved social functioning with their peers. This subgroup, moreover, is perceived by project directors to experience more than other subgroups, improved physical health and reduced suicide attempts as a result of intervention program participation.

Respondents indicated existing school AOD intervention efforts do not have a great impact on reducing cocaine or tobacco use. From available data, it was not possible to determine whether this is true because of ineffective program efforts or because the use of these substances is so small it doesn't require a great deal of attention. Most project directors said they do not think that intervention efforts greatly increase identification of child abuse and neglect cases or substantially reduce student contacts with law enforcement or court officials.

Appendix V contains the means of all favorable impacts listed on page four of both the prevention and intervention survey forms. These data are provided for the three populations included on the prevention survey and the seven populations included on the intervention survey. Table Three below contains rank ordered lists of the ten most favorable impacts of prevention and intervention programs for the above mentioned populations. The mean scores attached to each item reflect project directors' perceptions of program effectiveness.

Table 3 Program Impacts on Students

Prevention Program Impacts on Elementary School Students

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 81

Ten Greatest Perceived Impacts of Prevention Efforts on Elementary School Students Directly Receiving Services	Degree of Perceived Impact
1. Increased student knowledge of AOD use and/or abuse	3.81
2. Improved relations between students and school staff	3.08
3. Improved emotional/mental health of students	3.05
4. Improved relations between students and peers	2.97
5. Improved relations between students and their families	2.85
6. Reduced alcohol use among students	2.56
7. Delayed onset of AOD use and/or abuse	2.52
8. Reduced tobacco use among students	2.38
9. Improved physical health of students	2.36
10. Improved academic performance	2.18

Prevention Program Impacts on Middle/Junior High School Students

Ten Greatest Perceived Impacts of Prevention Efforts on Middle/Junior High School Students Directly Receiving Services	Degree of Perceived Impact
1. Increased student knowledge of AOD use and/or abuse	4.20
2. Improved relations between students and peers	3.25
3. Improved emotional/mental health of students	3.15
4. Improved relations between students and school staff	3.14
5. Reduced marijuana use among students	3.00
6. Reduced alcohol use among students	2.97
7. Improved relations between students and their families	2.86
8. Reduced tobacco use among students	2.69
9. Improved physical health of students	2.66
10. Delayed onset of AOD use and/or abuse	2.62

Program Impacts on Students (Table 3 continued)

Prevention Program Impacts on Senior High School Students

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 81

Ten Greatest Perceived Impacts of Prevention Efforts on Senior High Students Directly Receiving Services	Degree of Perceived Impact
1. Increased student knowledge of AOD use and/or abuse	4.13
2. Improved emotional/mental health of students	3.16
3. Improved relations between students and peers	3.03
4a. Improved relations between students and school staff	3.02
4b. Reduced marijuana use among students	3.02
5. Improved physical health of students	2.93
6. Reduced traffic accidents involving students	2.92
7. Improved relations between students and their families	2.89
8. Increase in student participation in extracurricular activities	2.77
9. Reduced alcohol use among students	2.74
10a. Delayed onset of AOD use and/or abuse	2.71
10b. Improved attendance	2.71

Intervention Program Impacts on Student AOD Users and/Abusers

No. of Respondents = 47

Ten Greatest Perceived Impacts of Intervention Efforts on AOD Users and/or Abusers Directly Receiving Services	Degree of Perceived Impact
1. Improved emotional/mental health of students	3.30
2. Improved social functioning between students and peers	3.14
3. Improved relations between students and school staff	3.10
4a. Improved academic performance	2.95
4b. Reduced marijuana use among students	2.95
5. Reduced alcohol use among students	2.88
6. Improved relations between students and their families	2.80
7. Improved school attendance	2.78
8. Increased participation in "alternative" social and recreational activities	2.77
9. Reduced suicide attempts	2.68
10. Improved physical health of students	2.67

Program Impacts on Students (Table 3 continued)

Intervention Program Impacts on Concerned Persons

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 47

	Ten Greatest Perceived Impacts of Intervention Efforts on Concerned Persons Directly Receiving Services	Degree of Perceived Impact
1.	Improved social functioning between students and peers	4.03
2.	Improved relations between students and school staff	3.85
3.	Improved emotional/mental health of students	3.82
4.	Improved academic performance	3.37
5.	Improved school attendance	3.30
6.	Increased participation in "alternative" social and recreational activities	3.29
7.	Improved relations between students and their families	3.20
8.	Reduced alcohol use among students	3.13
9.	Delayed onset of AOD use/abuse among students	3.09
10.	Improved physical health of students	3.00

Intervention Program Impacts on Recovering Students

	Ten Greatest Perceived Impacts of Intervention Efforts on Recovering Students Directly Receiving Services	Degree of Perceived Impact
1.	Reduced marijuana use among students	3.79
2.	Improved emotional/mental health of students	3.66
3.	Reduced alcohol use among students	3.56
4.	Improved relations between students and school staff	3.47
5.	Improved physical health of students	3.41
6.	Reduced suicide attempts	3.38
7a.	Improved school attendance	3.36
7b.	Improved academic performance	3.36
8.	Improved relations between students and their families	3.33
9.	Reduced school dropout rates	3.23
10.	Increased participation in "alternative" social and recreational activities	3.14

Program Impacts on Students (Table 3 continued)

Intervention Program Impacts on Elementary School Students

Degree of perceived impact as indicated by the average score of all respondents
on a six point scale with 0 lowest and 5 highest
No. of Respondents = 47

Ten Greatest Perceived Impacts of Intervention Efforts on Elementary School Students Directly Receiving Services	Degree of Perceived Impact
1. Delayed onset of AOD use/abuse among students	3.30
2. Improved emotional/mental health of students	3.16
3. Improved relations between students and school staff	3.03
4. Improved social functioning between students and peers	2.84
5. Increased participation in "alternative" social and recreational activities	2.68
6a. Improved relations between students and their families	2.66
6b. Improved academic performance	2.66
7. Decreased tobacco use among students	2.58
8a. Improved school attendance	2.50
8b. Increased identification of child abuse and neglect cases	2.50
9. Improved physical health of students	2.45
10. Reduced contacts with law enforcement and courts	2.24

Intervention Program Impacts on Middle/Junior High School Students

Ten Greatest Perceived Impacts of Intervention Efforts on Middle/Junior High School Students Directly Receiving Services	Degree of Perceived Impact
1. Improved emotional/mental health of students	3.32
2. Improved relations between students and school staff	3.18
3. Improved social functioning between students and peers	3.11
4. Delayed onset of AOD use/abuse among students	3.03
5. Improved relations between students and their families	2.89
6. Improved physical health of students	2.86
7. Increased participation in "alternative" social and recreational activities	2.82
8. Improved academic performance	2.76
9. Reduced alcohol use among students	2.71
10. Improved school attendance	2.68

Program Impacts on Students (Table 3 continued)

Intervention Program Impacts on Senior High School Students

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest
No. of Respondents = 47

Ten Greatest Perceived Impacts of Intervention Efforts on Senior High Students Directly Receiving Services	Degree of Perceived Impact
1. Improved emotional/mental health of students	3.53
2. Improved relations between students and school staff	3.44
3. Improved social functioning between students and peers	3.30
4. Reduced marijuana use among students	3.25
5. Improved school attendance	3.13
6. Improved relations between students and their families	3.08
7a. Reduced suicide attempts	3.06
7b. Increased participation in "alternative" social and recreational activities	3.06
8. Reduced alcohol use among students	3.05
9a. Reduced school dropout rates	3.00
9b. Improved physical health of students	3.00
10. Improved academic performance	2.95

Intervention Program Impacts on the Total Student Body

Ten Greatest Perceived Impacts of Intervention Efforts on the Total Student Population Directly Receiving Services	Degree of Perceived Impact
1. Improved emotional/mental health of students	3.47
2. Improved relations between students and school staff	3.33
3. Improved social functioning between students and peers	3.30
4. Improved school attendance	3.08
5. Increased participation in "alternative" social and recreational activities	3.06
6. Improved relations between students and their families	3.05
7. Reduced marijuana use among students	3.03
8a. Improved academic performance	2.97
8b. Reduced alcohol use among students	2.97
9. Improved physical health of students	2.89
10. Reduced suicide attempts	2.88

4. What favorable impacts do project directors perceive AOD prevention and intervention efforts to have on school staff, parents, and community members?

Prevention

Project directors viewed parental understanding and support of prevention projects as the greatest among 11 possible impacts. Community understanding and support were ranked second. Another highly ranked impact was an increased number of alcohol and other drug-free school and community activities.

AOD prevention efforts among grant receiving school districts do not greatly impact on the morale of teachers or other school staff. Also, such efforts have little effect on local enforcement of AOD-related laws or on gaining community financial contributions for school prevention efforts such as AOD–free activities. Thus, even though parents and other community members support school AOD prevention projects, they typically do not make financial contributions to schools specifically for these efforts.

Intervention

Improved parental and community understanding was viewed by project directors as the greatest favorable impact of their projects on nonstudent groups. This pattern resembles the perception of AOD prevention directors except that intervention project directors did not rank parental support as highly as their prevention counterparts. This may indicate that generally parental support for school intervention efforts is not as strong as it is for prevention efforts. Intervention projects are also perceived to enhance the school's ability to deal with non-AOD-related student problems, thereby improving the overall school climate. Project directors did not perceive intervention projects to have a substantial impact on the morale of school staff, the enforcement of AOD-related laws, and increased community financial contributions.

Table 4 Program Impacts on School Staff, Parents, and Community Members

Prevention Program Impacts

Degree of current emphasis as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 81

Perceived Impacts of Prevention Efforts On School Staff, Parents, and Community Members	Degree of Perceived Impact
1. Improved parental understanding of school district prevention efforts	3.58
2. Improved parental support for AOD prevention efforts	3.46
3. Improved community understanding of school district's AOD prevention efforts	3.30
4. Improved community support for AOD prevention efforts	3.28
5. Increased number of alcohol and other drug free school and/or community activities	3.23
6. Improved school climate	3.20
7. Improved effectiveness of school's ability to deal with non-AOD-related student problems	3.13
8. Improved morale among teachers	2.96
9. Improved morale among all school staff	2.78
10. Improved local enforcement of AOD-related laws (e.g., legal drinking age, drunk driving)	2.59
11. Increased community financial contributions for school prevention efforts	2.24

Intervention Program Impacts

No. of Respondents = 47

Perceived Impacts of Intervention Efforts On School Staff, Parents, and Community Members	Degree of Perceived Impact
1. Improved community understanding of school district's AOD intervention efforts	3.57
2. Improved parental understanding of school district intervention efforts	3.53
3. Improved community support for AOD intervention efforts	3.43
4. Improved effectiveness of school's ability to deal with non-AOD-related student problems	3.38
5. Improved school climate	3.34
6. Improved parental support of AOD intervention efforts	3.26
7. Increased number of alcohol and other drug free school and/or community activities	3.04
8. Improved morale among teachers	2.91
9. Improved morale among all school staff	2.83
10a. Increased community financial contributions for school intervention efforts	2.61
10b. Improved local enforcement of AOD-related laws (e.g., legal drinking age, drunk driving)	2.61

5. What factors inhibit school AOD prevention and/or intervention efforts?

Prevention

Prevention project directors indicated high rates of alcohol use in the community and at home present the greatest obstacles to reducing AOD-related problems among students. The second obstacle was lack of school staff time for prevention instruction, planning, and program evaluation. Many respondents expressed a need for more funding to release staff for prevention-related activities. Project directors and other school staff typically have several areas of responsibility in addition to providing AOD prevention services.

Another major inhibiting factor that surfaced in the survey results was parent, student, and community denial of problems related to AOD use. Lack of support for AOD prevention programs among these same groups, however, was not viewed as a major obstacle to providing services. Thus, even though students, parents, and community members may tend to deny the existence of AOD-related problems, they have generally supported school efforts to reduce such problems. Lack of appropriate staff training poses still another major inhibiting factor. Project directors expressed a great need to increase the number of workshops, inservice sessions and other training activities available to school staff. There was a strong consensus that not enough school staff have received training in both prevention and intervention.

Lack of support and involvement of law enforcement personnel, juvenile justice system personnel, general school staff, school board members, and administrative staff have not presented major obstacles in most districts. This finding was reinforced by project directors' responses to survey questions 1 and 2, which indicate an overall high degree of support and involvement of these groups in school prevention programs. Active opposition of community interest groups against AOD prevention efforts was ranked last of the 22 possible inhibiting factors. Respondents did express, however, difficulties in systematically coordinating school, community, and business/industry programs and resources. Problems have not been encountered in building support for AOD prevention efforts as much as in coordinating existing human and financial resources to enhance school efforts.

Intervention

Intervention project directors responded nearly the same as prevention project directors when asked about inhibiting factors. There was agreement that high rates of alcohol use in communities and homes present the greatest obstacles to reducing AOD-related problems, followed by lack of staff time for planning, service delivery, and program evaluation. One notable difference, however, is that intervention directors perceived denial of AOD problems as a bigger obstacle than their prevention counterparts.

Intervention directors did not perceive lack of support from school staff, school board members, parents, or community members to present major obstacles to service delivery. Lack of systematic coordination of school, community, and business/industry programs, however, was considered an obstacle inhibiting school efforts to assist students. Thus, both prevention and intervention project directors indicated general support for their projects yet the potential resources that may be available through cooperation and coordination with non-school providers have not been harnessed to enhance existing school efforts.

Table 5 The Ten Greatest Perceived Inhibiting Factors to Providing Services

Prevention

Degree to which a factor inhibits school efforts to provide services as indicated by the average score of all respondents on a six point scale with 0 lowest and 5 highest

No. of Respondents = 81

Ten Greatest Perceived Inhibiting Factors to Providing Services	Degree to Which Factors Inhibit Efforts
1. High rate of alcohol use in the community	3.73
2. High rate of alcohol use in the home	3.42
3. Lack of staff time for planning and evaluation of AOD prevention efforts	3.22
4. Lack of staff time for AOD prevention instruction	2.95
5. Parental denial of problems related to AOD use	2.88
6. Inadequate budget	2.75
7. Student denial of problems related to AOD use	2.72
8. Lack of systematic coordination with school/community/ business/industry programs and resources	2.68
9. Community denial of problems related to AOD use	2.60
10. Lack of appropriate staff training	2.38

Intervention

No. of Respondents = 47

Ten Greatest Perceived Inhibiting Factors to Providing Services	Degree to Which Factors Inhibit Efforts
1. High rate of alcohol use in the community	3.89
2. High rate of alcohol use in the home	3.74
3. Lack of staff time for service delivery including screening, student contact, and group facilitation	3.43
4. Parental denial of problems related to AOD use	3.40
5. Student denial of problems related to AOD use	3.36
6. Community denial of problems related to AOD use	3.21
7. Lack of staff time for planning and evaluation of AOD intervention efforts	3.15
8. Inadequate budget	2.77
9. High rate of other drug use in the home	2.65
10. High rate of other drug use in the community	2.60

6. What assistance would be most helpful to school districts to facilitate AOD prevention and intervention efforts?

Prevention

The most common responses to this question concerned staff training and inservice related to increasing the quality and quantity of AOD instruction. Suggested training topics included program evaluation techniques, curricular approaches, policy development, and revitalization of existing programs.

The second most common response was financial assistance for AOD efforts. Of the project directors listing financial assistance, more than one-third specified that such assistance should be used for staff release time for developing prevention curricula or other prevention-related tasks.

A number of school districts were interested in receiving assistance from outside experts to develop effective strategies for parent and community involvement. Interests ranged from AOD information dissemination to joint school/ community AOD prevention initiatives. Some districts specified a need to include procedures for parent/community involvement in a school board approved AOD policy.

Intervention

Intervention project directors expressed very nearly the same needs for assistance as prevention directors. The most frequent requests for assistance with intervention efforts in descending order were: (a) staff training, (b) financial assistance to provide release time for planning and support group facilitation, and (c) strategies for nurturing positive involvement of parents and other community members. Other types of assistance listed as potentially useful include program sharing opportunities, increased administrative support, and a clearly defined, school board approved AOD policy and procedure statement. Specific policy issues of interest include confidentiality, the role of volunteers or other non-school staff in AOD projects, and referral procedures.

Summary

The Wisconsin Alcohol and Other Drug School Grant Program (sec. 115.36(3)(a), Wis. Stats.) has served as an effective catalyst for motivating schools to develop and implement AOD prevention and intervention programs. Most school districts have maintained and often expanded their efforts in years subsequent to receiving grant funds. School programs are predominately school-based and do not systematically involve community members or agencies. Project directors generally view existing school-based programs as effective in addressing student AOD-related problems. There is, however, a perceived need to go beyond the current level of effort to provide comprehensive services for students at all grade levels. In many school districts there is a shortage of properly trained staff, thereby limiting the number of students receiving prevention instruction or intervention services.

The greatest obstacles to providing effective prevention and intervention services are high rates of AOD use in homes and communities; denial of AOD-related problems among students, parents, and other community members; and lack of staff time for prevention and intervention activities. Project directors indicated a need for schools to initiate greater involvement of parents, non-school AOD agencies, and other community organizations in school efforts. School districts recognize that isolated prevention and intervention programs are not enough to significantly reduce AOD-related problems among young people.

Recommendations for Practice and Policy Formation

Prevention

1. **More concerted efforts are needed to develop K-12 comprehensive prevention programs.** Current efforts to reduce AOD-related problems through preventive measures are interspersed across all grade levels in many of the school districts surveyed. AOD prevention instruction is typically provided in separate units in K-6 classrooms, middle school/junior high school health classes, and driver education classes. It appears that lapses exist where little, if any, AOD prevention instruction is provided. For instance, students in a number of reporting school districts do not receive AOD prevention instruction until seventh or eighth grade. This is reason for concern since successful preventive measures focus on decision making skills, peer refusal skills, and self-concept development (Education USA, 1986). These behaviors are most likely to be learned when instruction begins at a young age and is continued throughout a child's education. School districts need to examine the scope and sequence of their AOD prevention programs to determine if there are lapses from one grade level to another.

2. **AOD prevention instruction needs to be integrated with dropout prevention, suicide prevention, human growth and development education and other related areas.** AOD prevention instruction is often isolated in the overall school program. AOD abuse is one of many factors that may place a child's school and life success at risk. There is a need for schools to combine efforts that address these factors into a comprehensive program to deal with student services issues. A main

intent of this approach would be reducing fragmentation and providing services more efficiently. One method for interfacing these related areas is through the Wisconsin Developmental Guidance Model. This model offers a structure for providing age and maturation appropriate instruction and activities for AOD prevention and other pupil services issues. (Wisconsin Department of Public Instruction, 1986).

3. **Technical assistance provided by DPI to local school districts should focus on training to increase the number of school staff qualified in the area of AOD prevention.** This training could be provided by DPI staff or through direct financial assistance to schools or CESAs for training purposes. Specific training topics addressing the expressed needs of school district staff include prevention instruction techniques, curriculum selection and development, program evaluation, strategies for establishing school/community/business linkages, and AOD policy formation.

4. **School districts need to increase the involvement of community individuals and agencies in AOD prevention efforts**. Less than 25 percent of reporting districts had created school/community AOD councils or promoted regularly scheduled AOD-free school/community activities at the time of data collection. This finding is supported by an earlier study funded by the department on school efforts statewide to provide services for students who are at risk of school and life failure (Fredisdorf, 1986). Specifically, this study found that the majority of school district efforts to assist children at risk do not directly involve parents, business and industry, and other community members. One reason expressed by districts for this slow progress is an absence of well-defined, board approved AOD policies for guiding and promoting liaison activities with community individuals and agencies. Increasing this type of involvement should be made a priority because districts perceive that non-school factors present the greatest inhibitors to providing prevention services. There are AOD prevention and intervention financial and human resources in many communities that remain largely untapped by schools.

5. **Efforts need to be made to investigate potential uses and impacts of peer education.** Many districts have claimed substantial success using peer education techniques both for disseminating AOD knowledge and for teaching peer refusal skills, yet little empirical evidence is available to support this contention. These efforts could include controlled studies of the effects of peer education and program sharing opportunities. DPI and institutions of higher education are two entities that could take a lead in this area.

6. **State and local efforts are greatly needed to assess the impact of AOD prevention programs.** The DPI can take a leadership role in developing an evaluation process based on student AOD-related behavior. Evaluations of prevention programs, with few exceptions, are conducted in a cursory manner, if at all. Few school districts place emphasis on program evaluation, although most districts indicated a high desire to do so. Existing evaluation practices typically focus on student knowledge acquisition. No districts reported that data on student AOD use were systematically collected for evaluation purposes. Thus, there exists considerable uncertainty whether AOD prevention efforts actually reduce AOD use and/or abuse among students.

Intervention

1. **There is substantial need to increase the level of parent and community involvement in intervention programs.** This includes harnessing the efforts of parents and other community members, plus utilizing available community AOD agency services. School intervention programs would benefit from this course of action because: (a) school officials realize they alone cannot solve AOD-related problems that are rooted in the home and community, (b) human and financial resources are often inadequate to provide services to all students in need, (c) community involvement may foster greater understanding and support for intervention efforts, and (d) community AOD abuse and the denial of related problems are viewed as the primary inhibiting factors to service delivery.

   For the above reasons, school districts should take deliberate actions to increase the active involvement of parents and other community members or groups. Possible strategies for attaining this goal are listed below:

   - promotion of AOD intervention efforts through the local media
   - education programs for parents about AOD and how to deal with AOD-related problems
   - formation of AOD community advisory councils
   - AOD-free school/community activities
   - cooperative agreements with community AOD agencies for services such as screening, treatment and after-care
   - liaison activities with local law enforcement such as presentations to students by police officials

   To help ensure that parent and community involvement is constructive to program efforts, school districts need to have in place board-approved and legally sound AOD policies. The roles of parents, community members, law enforcement officials, community agencies, local businesses and other groups need to be clearly defined. Concise and well-publicized procedures are important to the positive participation of everyone working in the schools and community to reduce AOD-related problems.

2. **Because support groups are the mainstay of intervention programs, there is a need to examine activities taking place in these groups and to evaluate the programs in terms of student outcomes.** Project directors report considerable success in meeting the needs of students through support groups and have a great desire to increase their efforts in this area. Evaluation practices yielding empirical data of student AOD use patterns and other important outcomes are necessary to substantiate the claims of project directors about program effectiveness. This knowledge could be used to develop prototype or model programs for adaptation by school districts. DPI and institutions of higher education could provide leadership in this area because local school districts typically do not possess the technical background or finances required to carry on these research activities.

3. **Assistance to local school districts from state and federal government sources needs to focus on training more school personnel to be group facilitators.** Core team members do not have adequate time to facilitate support groups because of their

many other teaching and administrative responsibilities. To provide such training, DPI and other units of state and federal government could organize regional workshops for school district staff. Also, funds to be used specifically for staff training could be made available to districts or consortia. Among training topics of special interest to districts are support group facilitation, AOD policy development, and strategies for parental and community involvement.

4. **School districts need to re-examine their efforts to reduce cocaine and tobacco use.** Intervention project directors believe program efforts to have less impact on reducing cocaine and tobacco use than alcohol, marijuana or other chemical use. A recent national study shows, however, that the level of tobacco use, particularly among school age females, remains high. Also, the level of cocaine use among teenagers has continued to rise in recent years (Johnston et al., 1986). DPI could assist districts in studying student AOD use patterns. This would help to identify what substances youth are using and determine whether program efforts are properly addressing problem areas.

5. **Increased attention at both the local and state levels needs to be focused on service delivery to recovering students.** A relatively small number of recovering students are participating in support groups. From this study, it is not possible to ascertain why this is true, although it is likely that districts encounter more difficulties in meeting the needs of these students because their problems may be of a severe nature. There is uncertainty whether these students are receiving proper services and about the types of inhibiting factors that limit school district efforts to help them.

6. **Support groups should widen their focus to include a broader range of issues such as suicide, teen pregnancy, dropping out, and drunk driving.** The majority of project directors report that program efforts focus specifically on AOD intervention even though many complex and interrelated factors contribute to substance use. Research has demonstrated that programs teaching generic personal skills such as problem solving and decision making; cognitive and behavioral coping strategies for relieving stress and anxiety; and social skills such as communication skills, conversational skills, and assertiveness skills can help students deal with a broad range of issues not limited to substance use (Botvin, 1986). Thus, this relationship between the problems and solutions strongly supports school efforts that go beyond a narrow AOD focused approach. Most project directors expressed a strong desire to widen the scope of their programs. Shortages of trained staff, however, make such efforts difficult for many schools.

Wisconsin school districts receiving grants under sec. 115.36(3)(a), Wis. Stats., are generally providing the type of prevention instruction and intervention services identified as effective by recent research. Thousands of students have benefited from AOD prevention instruction and intervention services as a result of the grant program. No data have been systematically and longitudinally collected providing clear evidence of reduced levels of substance use among young people because of school AOD prevention and intervention programs. Nevertheless, the results of this study provide considerable cause for optimism about current and future successes in reducing AOD-related problems among Wisconsin youth.

References

Botvin, G. "Substance Abuse Prevention Research: Recent Developments and Future Directions." *Journal of School Health* 56 (1986), pp. 369-376..

Education USA. "The Drug Free School: What School Executives Can Do." Arlington, VA: National School Public Relations Association, 1986.

Fredisdorf, M.E., "The Effects of New Knowledge On Implementing Children at Risk Legislation." Diss. Univ. of Wisconsin – Madison, 1986.

Johnston, L.D., P.M. O'Malley, and J.G. Bachman. *Drug Use Among American High School Students, College Students, and Other Young Adults*. Rockville, MD: National Institute on Drug Abuse, 1986.

Wisconsin Department of Public Instruction. *School Counseling Programs: A Resource and Planning Guide*. Madison, WI: Department of Public Instruction, 1986.

Appendixes

A. Wisconsin Statutes Excerpt - Sec. 115.36(3)(a), Wis. Stats.

B. AOD Prevention Description

C. AOD Intervention Description

D. AOD Prevention and Intervention Survey Questionnaires

E. Average Responses of Project Directors on Prevention and Intervention Survey Items

Appendix A

Wisconsin Statutes Excerpt

Assistance to Schools for Alcohol and Other Drug Abuse Programs Grants for Demonstration Projects

Sec. 115.36 (3)(a), Wis. Stats.

(3) (a) The department shall, from the appropriation under s. 20.255 (2) (g), fund demonstration projects operated by public school districts which are designed to assist minors experiencing problems resulting from the use of alcohol or other drugs or to prevent alcohol or other drug abuse by minors. The department shall:

1. Administer grant application and disbursement of funds.
2. Monitor program implementation.
3. Assist in and assure evaluation of demonstration projects.
4. Report biennially in its report under s. 15.04(1)(d) on program progress and project evaluation.
5. Promulgate necessary rules for the implementation of this subsection.

(b) Grants under this subsection may not be used to replace funding available from other sources.

(c) Grants under this subsection may be made only where there is a matching fund contribution from the local area in which a program is designed to operate of 20% of the amount of the grant obtained under this subsection. Private funds and in-kind contribution may be applied to meet the requirement of this paragraph.

(d) A school district applying for aid under this subsection shall submit a copy of the application to the board established under s. 51.42 for its advisory review. The board established under s. 51.42 may, and the council established under sub. (2) (e) shall, submit an advisory recommendation with respect to the application to the department prior to the approval or denial of the application.

Appendix B

AOD Prevention*

Prevention programs refer to systematic efforts to provide pupils appropriate information and developmental experiences necessary to make personally and socially responsible decisions regarding their own AOD use and non-use, and to cope effectively with the personal and social results of decisions made by others regarding use. Appropriate information means providing current and accurate information. Developmental experiences mean both content and process must be consistent with the cognitive, affective and academic developmental stages of pupils. Instructional strategies or other service delivery techniques must provide for experiential learning opportunities. Responsible decision making must include consideration of the social impact of personal decisions; that is, the consequences such decisions have on others as well as the individual (e.g., driving while intoxicated, family disruption, fetal alcohol syndrome).

Making responsible decisions about one's own AOD use does not always prevent the types of problems which result indirectly from another's use (e.g., family member, friend, drunk-driver). Prevention also includes efforts to provide the types of information and experiences necessary to help students cope effectively with the potential results of the decisions of others.

Comprehensive AOD programs should include a continuum of knowledge/skill components which impact on the type of decisions that people will make about their own behavior and about their response to another's behavior regarding substance use.

Personal Competencies. This includes the types of knowledge and skills a person needs to assess themselves. Examples of personal competencies include: self-awareness, self-esteem, decision-making ability, value identification, and stress management.

Social Competencies. This includes the types of knowledge and skills persons need to assess themselves in relationship to others. Examples of social competencies include: communication skills, assertiveness skills and conflict management.

Social Systems. This includes the types of knowledge and skills persons need to assess themselves in relationship to the social groups and systems in which they operate. This includes both immediate social groups (i.e., the family and peer group), broader social groups (e.g., the school system, the local community, ethnic and cultural groups) and the society in general. Important aspects of social systems include: family relationships, peer group pressure, group and local norms, ethnic and cultural norms, public policy, legal sanctions and consequences.

AOD Information. This includes the types of skills and knowledge persons need to assess themselves in relation to alcohol and other drugs. Important types of information include: pharmacology, symptoms of problems and/or dependency, treatment modalities, medical emergency first aid and local resources and services.

A variety of program strategies can be utilized to provide pupils with appropriate information and experiences necessary to accomplish prevention goals. Examples include:

1. Establish a classroom curriculum dealing with AOD issues and develop a classroom climate conducive to open discussion of these issues.

2. Develop school-wide projects and develop a school climate conducive to discussion of AOD related issues.

3. Establish small groups which provide pupils with opportunities to examine personal AOD use decisions and patterns.

4. Establish extracurricular activities which provide pupils with opportunities to develop competencies and explore responsible alternatives to AOD use.

* *Excerpt from the Wisconsin Department of Public Instruction Alcohol and Other Drug School Demonstration Projects – Grant Program Handbook (Bulletin No. 4058).*

Appendix C

AOD Intervention*

Intervention programs refer to systematic efforts to respond to and provide appropriate assistance to pupils who demonstrate behaviors of concern which may indicate an AOD problem or who seek help for such problems themselves. Behaviors of concern include specific, observable behavior which may be inappropriate, unacceptable, irresponsible or dysfunctional for the individual. AOD problems include the type of personal, social and environmental problems which result either directly from a person's AOD use or indirectly from AOD use by a family member or significant others (e.g., chemical dependency, family disruption, driving while intoxicated, fetal alcohol syndrome). Intervention is a process which occurs in response to problems either observed or self-identified.

Comprehensive AOD intervention programs should include a continuum of service components which contribute to resolving existing substance abuse problems or maintaining change.

Identification and Assessment. This includes systematic efforts to observe individual behaviors which may indicate an AOD use problem and to provide opportunities for self-identification of possible problems. Assessment services provide for further evaluation of the type and severity of suspected problems.

In-School Assistance. This includes systematic efforts to provide pupils with identified AOD-related problems with appropriate assistance through school programs and services. These services typically focus on less severe use problems, problems resulting indirectly from another's use problems which require internal disciplinary action and self-identified problems of pupils who resist an outside referral.

Outside Referral. This includes systematic efforts to refer pupils to community resources and professionals when the presenting problem requires services which cannot be provided within the school setting or is more adequately dealt with outside the school. Examples of such problems include treatment for chemical dependency, medical emergencies, child abuse and neglect, life/safety threatening behaviors, behaviors requiring law enforcement intervention use problems when the school has a disciplinary handle on requiring outside referral, self-identified use and problems of students who are accepting of an outside referral.

After-Care Support. This includes systematic efforts to provide pupils who are receiving/have received assistance for AOD problems outside the school setting with special support and resources within the school to help facilitate and maintain change. Examples of needs in this area include: communication with treatment programs and community resources regarding pupil progress, support for individual pupils recovering from chemical dependency or use problems,and special tutoring/educational services for pupils with academic or learning prob' ms.

A variety of program strategies can be utilized to provide students with appropriate assistance for AOD-related problems. Examples include:

1. Establish systematic student assistance procedures:

   a) for staff to follow when observing/reporting behavior which may indicate an AOD-related pupil problem.

b) for pupils to follow when seeking help for self-identified problems.
c) for providing further assessment and determining appropriate action in terms of assistance, referral and/or discipline.
d) for situations requiring crisis intervention.
e) for communicating with treatment programs and resources.
f) for providing academic experience and credit while participating in treatment and/or returning from treatment.

2. Establish special individualized counseling and/or educational services for pupils who are receiving assistance for AOD-related problems.

3. Establish small group opportunities for pupils:

a) Assessment/Educational Groups: for pupils whose AOD use is causing problems.
b) Concerned Persons group: for pupils experiencing problems because of another's AOD use (friend, family member, etc.)
c) After-Care group: for pupils recovering from chemical dependency.
d) Non-Use groups: for pupils who have not experienced AOD-related problems and seek support in maintaining a non-use pattern.

* *Excerpt from the Wisconsin Department of Public Instruction Alcohol and Other Drug School Demonstration Projects – Grant Program Handbook (Bulletin No. 4058).*

Appendix D

THE STATE OF WISCONSIN • DEPARTMENT OF PUBLIC INSTRUCTION

125 South Webster Street • Box 7841 • Madison, Wisconsin 53707-7841

Herbert J. Grover, State Superintendent / Tim Quinn, Deputy State Superintendent

(608) 266-3390

October 27, 1986

Dear AOD Prevention Program Director:

I have recently announced plans for a statewide initiative to significantly reduce alcohol and other drug related problems among our youth. Our collective efforts are necessary if we are to successfully deal with this personal and social problem that presently jeopardizes the future of so many of our citizens. Important to these efforts, is the assessment of existing programs, problems, and needs relating to AOD prevention.

Your district has taken a lead in AOD prevention through previous involvement with our Alcohol and Other Drug Demonstration Grant Program. Knowledge of your ambitious and creative efforts in this area, therefore, would be of great value to the department and to the state. Your completion of the attached survey will enable us to build and improve AOD prevention resources from which all school districts may benefit.

Because your district received one or more grants for AOD prevention programming during the last five year period, the survey form focuses on prevention efforts. We ask, therefore, that you consider only your prevention efforts for this survey even though you may have intervention programs in place as well.

To insure quality control in conducting this survey, the department has contracted with the UW-Madison Survey Research Laboratory (SRL). Please complete the survey form and return it to the SRL in the envelope provided by November 21, 1986. The survey is designed to collect data for determining AOD prevention efforts statewide. Thus, it is not intended nor can it be used to evaluate your district's program.

Thank you for your time and cooperation in this survey. If you have questions or concerns about the survey or procedures, please call Dr. Mark Fredisdorf, Research Analyst, (608) 267-2947, Bureau for Pupil Services.

Sincerely,

Herbert J. Grover
State Superintendent

Enclosures

cc: Mark Fredisdorf, Research Analyst
Bureau for Pupil Services

D P I Wisconsin Department of Public Instruction
Alcohol and Other Drugs (AOD)
Bureau for Pupil Services
PREVENTION SURVEY
PI-Q86-10

INSTRUCTIONS: Complete and return by **November 21, 1986** to:

UNIVERSITY OF WISCONSIN-EXTENSION
ATTN: SURVEY RESEARCH LABORATORY
432 NORTH LAKE STREET
MADISON, WI 53791-9942

1. District Name	2. District Administrator	
3. Name and Title of AOD Prevention Program Director	4. Address of Program Director	5. Telephone of Program Director *Area/No.*

6. Name of AOD Prevention Program

7. Years your program has been in place *Check*

☐ before 1979 ☐ 1979-80 ☐ 1980-81 ☐ 1981-82 ☐ 1982-83 ☐ 1983-84 ☐ 1984-85 ☐ 1985-86 ☐ 1986-87

8. Years you have been directly involved with the program *Check*

☐ before 1979 ☐ 1979-80 ☐ 1980-81 ☐ 1981-82 ☐ 1982-83 ☐ 1983-84 ☐ 1984-85 ☐ 1985-86 ☐ 1986-87

9. Years you have served as AOD prevention program director *Check*

☐ before 1979 ☐ 1979-80 ☐ 1980-81 ☐ 1981-82 ☐ 1982-83 ☐ 1983-84 ☐ 1984-85 ☐ 1985-86 ☐ 1986-87

10. Number of participants under each classification who are currently active in the AOD prevention program:

a. **Number of School District Faculty/Staff:**

_____ Regular Teaching Staff
_____ School Nurse
_____ School Counselor
_____ School Social Worker
_____ School Psychologist
_____ Special Needs Staff (e.g., Chapter 1, Bilingual)
_____ Special Education Teachers (*e.g., EMR, ED*)
_____ Health Education Coordinator
_____ Other *Specify* _____

b. **Number of School Administrators/Supervisors**

_____ District Administrator
_____ Principals (*Elementary, Middle, High School*)
_____ Director of Curriculum/Instruction
_____ Director of Pupil Services
_____ Director of Special Education
_____ Others *Specify* _____

c. **Number of Other Participants**

_____ Parents
_____ Private School Staff
_____ Community AOD Agency Service Providers
_____ Community AOD Planning Board and/or Council Members
_____ School Board Members
_____ Law Enforcement Personnel
_____ Others *Specify* _____

11. District's Prevention Program has a focus on: *Check all that apply*

☐ Elementary Schools ☐ Middle/Jr. High Schools ☐ High Schools

12. Other Target Groups served by the program: *Check all that apply*

☐ Athletes ☐ Minority Students ☐ Special Education Students ☐ Culturally and/or Economically Disadvantaged Students
☐ Other *Specify* _____

13. Number of students served by AOD prevention program within the past school year _____ Males _____ Females

14. Training for AOD prevention staff has been provided by _____

15. District's AOD prevention program curriculum is: *Check* ☐ Purchased ☐ School Developed ☐ Combination Purchased/Sch. Dev.

If purchased, name of curriculum _____

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1. SCHOOL-BASED EFFORTS

The following is a partial listing of school-based efforts associated with AOD prevention programs. Indicate the degree of emphasis that was placed on each program area during the first year of your prevention program, the degree of current emphasis, and the degree of desired emphasis. If you have no knowledge of your program during the first year of operation, or if your program started during the 1985-86 school year, indicate only current and desired emphasis.

Item	Program Emphasis in 1st Year *Circle one* None			Med		High	Current Emphasis *Circle one* None			Med		High	Desired Emphasis *Circle one* None			Med.		High
a. Elementary school AOD instruction	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
b. Middle school/Junior high AOD instruction	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
c. High school AOD instruction	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
d. Administrative support of prevention program(s)	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
e. Direct administrative involvement in prevention program(s)	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
f. AOD taught in health education	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
g. AOD taught in driver education	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
h. AOD taught in biological sciences	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
i. AOD taught in home ec./family living	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
j. AOD taught in social studies	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
k. AOD taught in career education	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
l. Presentations to students by school staff about AOD prevention	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
m. Dissemination of AOD information to students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
n. School staff trained prior to teaching AOD	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
o. Inservice to inform all staff about AOD prevention	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
p. Systematic evaluation of AOD prevention program	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
q. Provisions for prevention services are built into athletic policies	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
r. Sex education issues are addressed in AOD prevention instruction	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
s. Peer groups [e.g., "Just Say No" groups] are operational	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
t. Peer refusal skills are developed	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
u. Prevention program includes counseling by school staff	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
v. Other *Specify* _____	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5

Comments:

2. COMBINED SCHOOL/COMMUNITY-BASED EFFORTS

The following is a partial listing of school/community-based efforts associated with AOD prevention programs. Indicate the degree of emphasis that was placed on each program area during the first year of your prevention program, the degree of current emphasis, and the degree of desired emphasis. If you have no knowledge of your program during the first year of operation, or if your program started during the 1985-86 school year, indicate only current and desired emphasis.

Item	Program Emphasis in 1st Year *Circle one* None Med. High	Current Emphasis *Circle one* None Med. High	Desired Emphasis *Circle one* None Med. High
a. Liaison relations and/or agreements with local law enforcement	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
b. Liaison relations and/or agreements with juvenile court system or Health and Social Services	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
c. Cooperative efforts with public or private community AOD agencies	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
d. Cooperative efforts with community AOD supportive groups (*e.g., churches, councils, service organizations*)	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
e. Systematic involvement of parents in AOD prevention efforts	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
f. Presentations to students by community professionals or other nonschool staff	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
g. Dissemination of information to parents about AOD prevention	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
h. Media attention and other efforts to gain community support	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
i. Training sessions and inservices for community members/parents about AOD use and/or abuse prevention	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
j. Parents are informed of student participation in AOD prevention programs	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
k. Outside contributions are solicited to support the AOD prevention program	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
l. Other *Specify* _____	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5

Comments:

3. FAVORABLE STUDENT IMPACTS

Items a-q are favorable impacts that an AOD prevention program may have on students. Indicate the degree to which you perceive that your prevention efforts have created each of the following impacts on: (1) Elementary students, (2) Middle School/Junior High students, and (3) Senior High students.

Perceived Impacts of Prevention Program on Students Directly Receiving Services	(1) Elementary School Students — *Circle one* None			Med.		High	(2) Middle School/ Jr. High Students — *Circle one* None			Med.		High	(3) Senior High Students — *Circle one* None			Med.		High
a. Improved relations between students and peers	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
b. Improved relations between students and school staff	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
c. Improved relations between students and their families	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
d. Improved academic performance	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
e. Reduced alcohol use among students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
f. Reduced marijuana use among students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
g. Reduced cocaine use among students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
h. Reduced other chemical use among students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
i. Reduced tobacco use among students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
j. Improved physical health of students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
k. Improved emotional/mental health of students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
l. Increased student knowledge of AOD use and/or abuse	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
m. Reduced traffic accidents involving students	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
n. Prolonged onset of AOD use and/or abuse	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
o. Improved attendance	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
p. Reduced dropout rates	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
q. Increase in student participation in extracurricular activities	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
r. Other *Specify* _____	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5

Comments:

4. FAVORABLE IMPACTS ON SCHOOL STAFF, PARENTS AND COMMUNITY MEMBERS

Items a-k are favorable impacts that an AOD prevention program may have on school staff, parents, and community members. Indicate the degree of impact which you perceive that your prevention program efforts have had on each of the following:

Perceived Impacts of Prevention Program on School Staff, Parents and Community Members	Degree of Impact *Circle one* None			Med		High
a. Improved morale among teachers	0	1	2	3	4	5
b. Improved morale among all school staff	0	1	2	3	4	5
c. Improved parental understanding of school district prevention efforts	0	1	2	3	4	5
d. Improved parental support for AOD prevention efforts	0	1	2	3	4	5
e. Improved community understanding of school district's AOD prevention efforts	0	1	2	3	4	5
f. Improved community support for AOD prevention efforts	0	1	2	3	4	5
g. Improved school climate	0	1	2	3	4	5
h. Improved effectiveness of school's ability to deal with non-AOD related student problems	0	1	2	3	4	5
i. Increased number of alcohol and other drug free school and/or community activities	0	1	2	3	4	5
j. Increased community financial contributions for school prevention efforts	0	1	2	3	4	5
k. Improved local enforcement of AOD related laws (e.g., legal drinking age, drunk driving)	0	1	2	3	4	5
l. Other *Specify* _____	0	1	2	3	4	5

5. INHIBITING FACTORS

Serving students through AOD prevention efforts is a complex and difficult task. Often school districts must overcome inhibiting factors in accomplishing this goal. Indicate to what degree the following factors inhibit your district's effectiveness to serve students through AOD prevention efforts.

Inhibiting Factors	Not a Factor *Circle One*			Med		High
a. Inadequate budget	0	1	2	3	4	5
b. Lack of coordination of school-based AOD prevention efforts	0	1	2	3	4	5
c. Lack of staff time for AOD prevention instruction	0	1	2	3	4	5
d. Lack of staff time for planning and evaluation of AOD prevention efforts	0	1	2	3	4	5
e. Lack of administrative support	0	1	2	3	4	5
f. Lack of general staff support	0	1	2	3	4	5
g. Lack of parental support for school AOD prevention efforts	0	1	2	3	4	5
h. Lack of community support for school AOD prevention efforts	0	1	2	3	4	5
i. Lack of School Board support for AOD prevention efforts	0	1	2	3	4	5
j. High rate of alcohol use in the home	0	1	2	3	4	5
k. High rate of other drug use in the home	0	1	2	3	4	5
l. High rate of alcohol use in the community	0	1	2	3	4	5
m. High rate of other drug use in the community	0	1	2	3	4	5
n. Lack of involvement of local law enforcement personnel	0	1	2	3	4	5
o. Lack of involvement of juvenile justice system personnel	0	1	2	3	4	5
p. Lack of systematic coordination with school/community/business/industry programs and resources	0	1	2	3	4	5
q. Staff turnover	0	1	2	3	4	5
r. Lack of appropriate staff training	0	1	2	3	4	5
s. Active opposition of community interest groups against AOD prevention efforts	0	1	2	3	4	5
t. Community denial of problems related to AOD use	0	1	2	3	4	5
u. Student denial of problems related to AOD use	0	1	2	3	4	5
v. Parental denial of problems related to AOD use	0	1	2	3	4	5
w. Other *Specify* _____	0	1	2	3	4	5

6. NARRATIVE

Please respond to the following questions. Attach additional sheets if necessary

1. Briefly describe your prevention program efforts:

2. Which AOD prevention efforts have had the greatest positive effects/impacts on students?

3. Briefly describe any intervention efforts, in addition to prevention efforts, currently being made in your school district:

4. Indicate the type of assistance that would be most helpful to your school to facilitate AOD prevention efforts:

THE STATE OF WISCONSIN • DEPARTMENT OF PUBLIC INSTRUCTION
125 South Webster Street • Box 7841 • Madison, Wisconsin 53707-7841
Herbert J. Grover, State Superintendent / Tim Quinn, Deputy State Superintendent
(608) 266-3390

October 24, 1986

Dear AOD Intervention Program Director:

I have recently announced plans for a statewide initiative to significantly reduce alcohol and other drug related problems among our youth. Our collective efforts are necessary if we are to successfully deal with this personal and social problem that presently jeopardizes the future of so many of our citizens. Important to these efforts, is the assessment of existing programs, problems, and needs relating to AOD prevention.

Your district has taken a lead in AOD intervention through previous involvement with our Alcohol and Other Drug Demonstration Grant Program. Knowledge of your ambitious and creative efforts in this area, therefore, would be of great value to the department and to the state. Your completion of the attached survey will enable us to build and improve AOD intervention resources from which all school districts may benefit.

Because your district received one or more grants for AOD intervention programming during the last five year period, the survey form focuses on intervention efforts. We ask, therefore, that you consider only your intervention efforts for this survey even though you may have prevention programs in place as well.

To insure quality control in conducting this survey, the department has contracted with the UW-Madison Survey Research Laboratory (SRL). Please complete the survey form and return it to the SRL in the envelope provided by November 21, 1986. The survey is designed to collect data for determining AOD intervention efforts statewide. Thus, it is not intended nor can it be used to evaluate your district's program.

Thank you for your time and cooperation in this survey. If you have questions or concerns about the survey or procedures, please call Dr. Mark Fredisdorf, Research Analyst, (608) 267-2947, Bureau for Pupil Services.

Sincerely,

Herbert J. Grover
State Superintendent

Enclosures

cc: Mark Fredisdorf, Research Analyst
Bureau for Pupil Services

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D P I

Wisconsin Department of Public Instruction
Alcohol and Other Drugs (AOD)
Bureau for Pupil Services
INTERVENTION SURVEY
PI-Q86-11

INSTRUCTIONS: Complete and return by **November 21, 1986** to:

UNIVERSITY OF WISCONSIN-EXTENSION
ATTN: SURVEY RESEARCH LABORATORY
432 NORTH LAKE STREET
MADISON, WI 53791-9942

1. District Name	2. District Administrator	
3. Name and title of AOD Intervention Program Director	4. Address of Program Director	5. Telephone of Project Director *Area/No.*

6. Name of AOD Intervention Program

7. Nature of your AOD intervention program. *Check one*

☐ AOD related problems are primary focus of program
☐ Generic focus on a wide variety of problems with AOD intervention as a sub-component
For survey purposes, base responses on the AOD intervention component of your broader program.

8. Years your program has been in place *Check*

☐ before 1979 ☐ 1980-81 ☐ 1982-83 ☐ 1984-85 ☐ 1986-87
☐ 1979-80 ☐ 1981-82 ☐ 1983-84 ☐ 1985-86

9. Years you have been directly involved with the program *Check*

☐ before 1979 ☐ 1980-81 ☐ 1982-83 ☐ 1984-85 ☐ 1986-87
☐ 1979-80 ☐ 1981-82 ☐ 1983-84 ☐ 1985-86

10. Years you have served as AOD intervention program director *Check*

☐ before 1979 ☐ 1980-81 ☐ 1982-83 ☐ 1984-85 ☐ 1986-87
☐ 1979-80 ☐ 1981-82 ☐ 1983-84 ☐ 1985-86

11. Number of participants under each classification who are designated members of a core team or who are otherwise currently active in the AOD intervention program:

a. **Number of School District Faculty/Staff:**

_____ Regular Teaching Staff
_____ School Nurse
_____ School Counselor
_____ School Social Worker
_____ School Psychologist
_____ Special Needs Staff (e.g., Chapter 1, Bilingual)
_____ Special Education Teachers (*e.g., EMR, ED*)
_____ Health Education Coordinator
_____ Other *Specify* _____

b. **Number of School Administrators/Supervisors**

_____ District Administrator
_____ Principals (*Elementary, Middle, High School*)
_____ Director of Curriculum/Instruction
_____ Director of Pupil Services
_____ Director of Special Education
_____ Others *Specify* _____

c. **Number of Other Participants**

_____ Parents
_____ Private School Staff
_____ Community AOD Agency Service Providers
_____ Community AOD Planning Board and/or Council Members
_____ School Board Members
_____ Law Enforcement Personnel
_____ Others *Specify* _____

12. District's Intervention Program has a focus on: *Check all that apply*

☐ Elementary Schools ☐ Middle/Jr. High Schools ☐ High Schools

13. *Other Target Groups served by the program: Check all that apply*

☐ Athletes ☐ Minority Students ☐ Special Education Students ☐ Culturally and/or Economically Disadvantaged Students
☐ Other *Specify* _____

14. Number of students served by AOD intervention program within the past school year under each classification:

AOD Dependent	Concerned Persons	AOD Users (non dependent)	Recovering	Other *Specify*

1. SCHOOL-BASED EFFORTS

The following is a partial listing of school-based efforts associated with AOD intervention programs. Indicate the degree of emphasis that was placed on each program area during the first year of your intervention program, the degree of current emphasis, and the degree of desired emphasis. If you have no knowledge of your program during the first year of operation, or if your program started during the 1985-86 school year, indicate only current and desired emphasis.

Item	Program Emphasis in 1st Year *Circle one* None			Med.		High	Current Emphasis *Circle one* None			Med.		High	Desired Emphasis *Circle one* None			Med.		High
a. Support group(s) for AOD use and/or abuse problems.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
b. Support group(s) for concerned persons.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
c. Support group(s) for aftercare/recovery.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
d. Educational/Academic provisions for students in AOD treatment.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
e. Educational/Academic provisions for students after treatment.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
f. Individual counseling provided by teachers, counselors or other school staff.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
g. Systematic procedures for student screening or preassessment.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
h. Systematic procedures for student referral within school.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
i. Systematic procedures for student referral outside of school.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
j. Dissemination of general AOD information to students.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
k. Presentations by school staff to students about the school's AOD program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
l. Students excused from class to participate in group sessions.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
m. Athletic AOD policies result in referral to intervention program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
n. Peer counseling component in the intervention program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
o. Sex education issues are addressed within AOD support groups.	0	1	2	3	4	5	0	1	2	3		5	0	1	2	3	4	5
p. Suicide issues are addressed in AOD support groups.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
q. Comprehensive initial training for core group staff members.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
r. Ongoing advanced training for core group staff members.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
s. Training for school staff to conduct screening or reassessment.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
t. Inservice to inform all staff members about intervention efforts.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
u. Administrative support of intervention program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
v. Direct administrative involvement in intervention program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
w. Systematic evaluation of AOD intervention program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
x. Employee assistance program(s).	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
y. Well-defined, Board approved AOD policy and procedure statement.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
z. Other *Specify* _____	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5

2. COMBINED SCHOOL/COMMUNITY-BASED EFFORTS

The following is a partial listing of school/community-based efforts associated with AOD intervention programs. Indicate the degree of emphasis that was placed on each program area during the first year of your intervention program, the degree of current emphasis, and the degree of desired emphasis. If you have no knowledge of your program during the first year of operation, or if your program started during the 1985-86 school year, indicate only current and desired emphasis.

Item	Program Emphasis in 1st Year *Circle one* None			Med.		High	Current Emphasis *Circle one* None			Med.		High	Desired Emphasis *Circle one* None			Med.		High
a. Liaison relations and/or agreements with local law enforcement.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
b. Liaison relations and/or agreements with juvenile court system or human and social services.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
c. Cooperative efforts with community or county AOD agencies, councils or organizations (e.g., 51.42 Boards, AOD councils).	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
d. Cooperative efforts with community AOD supportive groups (e.g., churches, service organizations).	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
e. Cooperative efforts with community self-help groups (e.g., AA, Alanon, Alateen).	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
f. Cooperative efforts with inpatient treatment agencies.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
g. Systematic involvement of parents in intervention efforts.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
h. Presentations to students by community professionals or outside speakers.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
i. Dissemination of written information to parents about AOD programs.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
j. Access to professional outside AOD diagnostic services.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
k. Media attention and other efforts to gain community support.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
l. Training sessions and inservices for community members/parents regarding AOD program and AOD information.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
m. AOD information included in a local telephone hotline.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
n. Outside contributions are acquired to support the intervention program.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
o. AOD-related support groups for parents.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
p. Use of community members/parents as core team members.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
q. Use of community members/parents as group facilitators.	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
r. Other *Specify* _____	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5

Comments:

3. FAVORABLE STUDENT IMPACTS

Items a-r are favorable impacts that an AOD intervention program may have on students served through such efforts. Indicate the degree to which you perceive that your intervention efforts have created each of the following impacts on: (1) AOD users and/or abusers, (2) concerned persons, (3) recovering students, (4) elementary students, (5) middle school/junior high students, (6) senior high school students, and (7) the total school population.

Target Populations Directly Served by Intervention Program

Perceived Impacts of Intervention Program on Students Directly Receiving Services	1. AOD Users and/or Abusers	2. Concerned Persons	3. Recovering Students	4. Elementary Students	5. Middle School/Junior High Students	6. Senior High Students	7. Total Student Population
	Circle one None Med High	*Circle one* None Med High	*Circle one* None Med High	*Circle one* None Med High	*Circle one* None Med High	*Circle one* None Med High	*Circle one* None Med High
a. Improved social functioning between students and peers.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
b. Improved relations between students and school staff.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
c. Improved relations between students and their families.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
d. Improved academic performance.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
e. Reduced alcohol use among students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
f. Reduced marijuana use among students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
g. Reduced cocaine or "crack" use among students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
h. Decreased tobacco use among students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
i. Reduced use of any other drugs among students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
j. Improved physical health of students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
k. Improved emotional/mental health of students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
l. Reduced school dropout rates.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
m. Reduced contacts with law enforcement and courts.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
n. Reduced suicide attempts.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
o. Delayed onset of AOD use/abuse among students.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
p. Improved school attendance.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
q. Increased participation in "alternative" social and recreational activities.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
r. Increased identification of child abuse and neglect cases.	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
s. Other *Specify* _____	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5

4. FAVORABLE IMPACTS ON SCHOOL STAFF, PARENTS AND COMMUNITY MEMBERS

Items a-k are favorable impacts that an AOD intervention program may have on school staff, parents, and community members. Indicate the degree of impact which you perceive your intervention program efforts to have had on each of the following:

Perceived Impacts of Intervention Program on School Staff, Parents, and Community Members	Degree of Impact *Circle one* None			Med		High
a. Improved morale among teachers	0	1	2	3	4	5
b. Improved morale among all school staff	0	1	2	3	4	5
c. Improved parental understanding of school district intervention efforts	0	1	2	3	4	5
d. Improved parental support for AOD intervention efforts	0	1	2	3	4	5
e. Improved community understanding of school district's AOD intervention efforts	0	1	2	3	4	5
f. Improved community support for AOD intervention efforts	0	1	2	3	4	5
g. Improved school climate	0	1	2	3	4	5
h. Improved effectiveness of school's ability to deal with non-AOD related student problems	0	1	2	3	4	5
i. Increased number of alcohol and other drug free school and/or community activities	0	1	2	3	4	5
j. Increased community financial contributions for school intervention efforts	0	1	2	3	4	5
k. Improved local enforcement of AOD related laws (e.g., legal drinking age, drunk driving)	0	1	2	3	4	5
l. Other *Specify* _____	0	1	2	3	4	5

5. INHIBITING FACTORS

Serving students through AOD intervention efforts is a complex and difficult task. Often school districts must overcome inhibiting factors in accomplishing this goal. Indicate to what degree the following factors inhibit your district's effectiveness to serve students through AOD intervention efforts.

Inhibiting Factors	*Circle one* Not a factor			Med.		High
a. Inadequate budget	0	1	2	3	4	5
b. Lack of coordination of school-based AOD intervention efforts	0	1	2	3	4	5
c. Lack of staff time for service delivery including screening, student contact, and group facilitation	0	1	2	3	4	5
d. Lack of staff time for planning and evaluation of AOD intervention efforts	0	1	2	3	4	5
e. Lack of administrative support	0	1	2	3	4	5
f. Lack of general staff support	0	1	2	3	4	5
g. Lack of parental support for school AOD intervention efforts	0	1	2	3	4	5
h. Lack of community support for school AOD intervention efforts	0	1	2	3	4	5
i. Lack of School Board support for school AOD intervention services	0	1	2	3	4	5
j. High rate of alcohol use in the home	0	1	2	3	4	5
k. High rate of other drug use in the home	0	1	2	3	4	5
l. High rate of alcohol use in the community	0	1	2	3	4	5
m. High rate of other drug use in the community	0	1	2	3	4	5
n. Lack of involvement of local law enforcement personnel	0	1	2	3	4	5
o. Lack of involvement of juvenile justice system personnel	0	1	2	3	4	5
p. Lack of systematic coordination with school/community/business/industry programs and resources	0	1	2	3	4	5
q. Staff turnover	0	1	2	3	4	5
r. Lack of appropriate staff training	0	1	2	3	4	5
s. Active opposition of community interest groups against school AOD intervention efforts	0	1	2	3	4	5
t. Community denial of problems related to AOD use	0	1	2	3	4	5
u. Student denial of problems related to AOD use	0	1	2	3	4	5
v. Parental denial of problems related to AOD use	0	1	2	3	4	5
w. Other *Specify* _____	0	1	2	3	4	5

6. NARRATIVE

Please respond to the following questions. Attach additional sheets if necessary.

1. Briefly describe your intervention program efforts:

2. Which AOD intervention efforts have had the greatest positive impacts on students?

3. Briefly describe any prevention efforts, in addition to intervention efforts, currently being made in your school district:

4. Indicate the type of assistance that would be most helpful to your school to facilitate AOD intervention efforts:

5. Who has provided training for AOD intervention staff?

Appendix E

Prevention

Degree of Emphasis of School Based Prevention Efforts Among Grant Recipients as Indicated by the Average Score of Prevention Project Directors (No. of Respondents = 81) on a Six Point Scale with 0 Lowest and 5 Highest.

Item	Program Emphasis in 1st Year	Current Emphasis	Desired Emphasis
a. Elementary school AOD instruction	3.36	3.54	4.49
b. Middle school/Junior high AOD instruction	3.28	3.57	4.40
c. High school AOD instruction	2.67	2.97	4.26
d. Administrative support of prevention program(s)	3.93	3.92	4.58
e. Direct administrative involvement in prevention program(s)	3.15	3.13	4.04
f. AOD taught in health education	3.56	3.91	4.35
g. AOD taught in driver education	2.79	3.03	3.66
h. AOD taught in biological sciences	1.70	2.00	3.08
i. AOD taught in home ec./family living	2.07	2.37	3.15
j. AOD taught in social studies	1.84	2.00	3.01
k. AOD taught in career education	.67	.83	2.01
l. Presentations to students by school staff about AOD prevention	3.07	3.19	3.85
m. Dissemination of AOD information to students	3.57	3.61	4.31
n. School staff trained prior to teaching AOD	3.62	3.31	4.31
o. Inservice to inform all staff about AOD prevention	3.38	2.70	3.91
p. Systematic evaluation of AOD prevention program	3.30	2.67	3.99
q. Provisions for prevention services are built into athletic policies	2.27	2.75	4.00
r. Sex education issues are addressed in AOD prevention instruction	1.37	1.53	2.80
s. Peer groups [e.g., "Just Say No" groups] are operational	1.78	2.03	3.72
t. Peer refusal skills are developed	2.90	3.16	4.21
u. Prevention program includes counseling by school staff	3.31	3.39	4.24

Prevention (continued)

Degree of Emphasis of School/Community-Based Prevention Efforts Among Grant Recipients as Indicated by the Average Score of Prevention Project Directors (No. of Respondents = 81) on a Six Point Scale with 0 Lowest and 5 Highest.

Item	Program Emphasis in 1st Year	Current Emphasis	Desired Emphasis
a. Liaison relations and/or agreements with local law enforcement	2.39	2.78	3.96
b. Liaison relations and/or agreements with juvenile court system or Health and Social Services	2.07	2.44	3.72
c. Cooperative efforts with public or private community AOD agencies	2.98	3.41	4.05
d. Cooperative efforts with community AOD supportive groups (e.g., churches, councils, service organizations)	2.48	2.77	3.91
e. Systematic involvement of parents in AOD prevention efforts	2.56	2.68	4.18
f. Presentations to students by community professionals or other nonschool staff	3.12	3.12	3.99
g. Dissemination of information to parents about AOD prevention	3.10	3.15	4.25
h. Media attention and other efforts to gain community support	2.80	2.84	3.94
i. Training sessions and inservice for community members/parents about AOD use and/or abuse prevention.	2.54	2.43	3.81
j. Parents are informed of student participation in AOD prevention programs	3.17	3.14	4.03
k. Outside contributions are solicited to support the AOD prevention program	1.68	1.81	2.88

Prevention (continued)

Perceived Degree to Which Prevention Efforts Have Created Favorable Impacts on Student Populations Directly Receiving Services as Indicated by the Average Score of Prevention Project Directors (No. of Respondents = 81) on a Six Point Scale with 0 Lowest and 5 Highest.

Perceived Impact of Prevention Program on Students Directly Receiving Services	Elementary School Students	Middle School/ Junior High Students	Senior High Students
a. Improved relations between students and peers	2.97	3.25	3.03
b. Improved relations between students and school staff	3.08	3.14	3.02
c. Improved relations between students and their families	2.85	2.86	2.89
d. Improved academic performance	2.18	2.53	2.57
e. Reduced alcohol use among students	2.56	2.97	2.74
f. Reduced marijuana use among students	2.09	3.00	3.02
g. Reduced cocaine use among students	1.57	2.24	2.39
h. Reduced other chemical use among students	1.94	2.55	2.66
i. Reduced tobacco use among students	2.38	2.69	2.67
j. Improved physical health of students	2.36	2.66	2.93
k. Improved emotional/mental health of students	3.05	3.15	3.16
l. Increased student knowledge of AOD use and/or abuse	3.81	4.20	4.13
m. Reduced traffic accidents involving students	1.20	1.63	2.92
n. Prolonged onset of AOD use and/or abuse	2.52	2.62	2.71
o. Improved attendance	2.00	2.60	2.71
p. Reduced dropout rates	1.57	2.12	2.58
q. Increase in student participation in extracurricular activities	1.85	2.48	2.77

Prevention (continued)

Degree to Which Factors Inhibit School Prevention Efforts as Indicated by the Average Score of Prevention Project Directors (No. of Respondents = 81) on a Six Point Scale with 0 Lowest and 5 Highest.

Inhibiting Factors	Degree to Which Factors Inhibit Prevention Efforts
a. Inadequate budget	2.75
b. Lack of coordination of school-based AOD prevention efforts	2.11
c. Lack of staff time for AOD prevention instruction	2.95
d. Lack of staff time for planning and evaluation of AOD prevention efforts	3.22
e. Lack of administrative support	1.39
f. Lack of general staff support	2.04
g. Lack of parental support for school AOD prevention efforts	2.05
h. Lack of community support for school AOD prevention efforts	2.18
i. Lack of School Board support for AOD prevention efforts	1.55
j. High rate of alcohol use in the home	3.42
k. High rate of other drug use in the home	1.90
l. High rate of alcohol use in the community	3.73
m. High rate of other drug use in the community	2.16
n. Lack of involvement of local law enforcement personnel	1.76
o. Lack of involvement of juvenile justice system personnel	1.83
p. Lack of systematic coordination with school/-community/business/industry programs and resources	2.68
q. Staff turnover	1.59
r. Lack of appropriate staff training	2.38
s. Active opposition of community interest groups against AOD prevention efforts	.91
t. Community denial of problems related to AOD use	2.60
u. Student denial of problems related to AOD use	2.72
v. Parental denial of problems related to AOD use	2.88

Intervention

Degree of Emphasis of School Based Intervention Efforts Among Grant Recipients as Indicated by the Average Score of Intervention Project Directors (No. of Respondents = 47) on a Six Point Scale with 0 Lowest and 5 Highest.

Item	Program Emphasis in 1st Year	Current Emphasis	Desired Emphasis
a. Support group(s) for AOD use and/or abuse problems	3.53	3.63	4.33
b. Support group(s) for concerned persons	3.75	4.06	4.65
c. Support group(s) for after-care/recovery	2.46	2.58	3.89
d. Educational/Academic provisions for students in AOD treatment	2.10	2.77	3.77
e. Educational/Academic provisions for students after treatment	2.00	2.72	4.00
f. Individual counseling provided by teachers, counselors or other school staff	3.40	3.60	4.15
g. Systematic procedures for student screening or preassessment	3.18	3.57	4.37
h. Systematic procedures for student referral within school	3.38	3.64	4.53
i. Systematic procedures for student referral outside of school	2.85	3.15	4.15
j. Dissemination of general AOD information to students	3.28	3.47	4.26
k. Presentations by school staff to students about the school's AOD program	3.45	3.33	4.17
l. Students excused from class to participate in group sessions.	3.65	3.94	4.54
m. Athletic AOD policies result in referral to intervention program.	2.38	3.35	4.04
n. Peer counseling component in the intervention program	1.08	1.28	2.74
o. Sex education issues are addressed within AOD support groups	1.30	1.64	2.74
p. Suicide issues are addressed in AOD support groups	1.95	2.64	3.61
q. Comprehensive initial training for core group staff members	4.15	3.51	4.26
r. Ongoing advanced training for core group staff members	2.53	3.06	4.13
s. Training for school staff to conduct screening or reassessment	2.44	2.65	3.44
t. Inservice to inform all staff members about intervention efforts	3.82	3.02	4.09
u. Administrative support of intervention program	3.70	3.72	4.48
v. Direct administrative involvement in intervention program	3.18	2.70	3.89
w. Systematic evaluation of AOD intervention program	3.25	2.77	3.87
x. Employee assistance program(s)	1.03	1.83	3.40
y. Well-defined, Board approved AOD policy and procedure statement	3.82	4.00	4.45

Intervention (continued)

Degree of Emphasis of School/Community Based Intervention Efforts Among Grant Recipients as Indicated by the Average Score of all Intervention Project Directors (No. of Respondents = 47) on a Six Point Scale with 0 Lowest and 5 Highest.

Item	Program Emphasis in 1st Year	Current Emphasis	Desired Emphasis
a. Liaison relations and/or agreements with local law enforcement	2.38	2.91	4.24
b. Liaison relations and/or agreements with juvenile court system or human and social services	2.05	2.64	3.98
c. Cooperative efforts with community or county AOD agencies, councils or organizations (e.g., 51.42 Boards, AOD councils)	3.22	3.60	4.57
d. Cooperative efforts with community AOD supportive groups (e.g., churches, service organizations)	2.57	2.79	4.00
e. Cooperative efforts with community self-help groups (e.g., AA, Alanon, Alateen)	2.05	2.45	3.83
f. Cooperative efforts with inpatient treatment agencies	2.43	3.23	4.22
g. Systematic involvement of parents in intervention efforts	2.28	2.72	3.91
h. Presentations to students by community professionals or outside speakers	3.65	3.26	3.91
i. Dissemination of written information to parents about AOD programs	3.65	3.23	4.13
j. Access to professional outside AOD diagnostic services	3.41	3.68	4.20
k. Media attention and other efforts to gain community support	3.33	2.85	3.72
l. Training sessions and inservice for community members/parents regarding AOD program and AOD information	3.09	2.38	3.59
m. AOD information included in a local telephone hotline	1.00	1.13	2.14
n. Outside contributions are acquired to support the intervention program	1.84	1.96	3.13
o. AOD-related support groups for parents	1.00	.91	2.88
p. Use of community members/parents as core team members	2.57	2.06	3.24
q. Use of community members/parents as group facilitators	1.49	1.77	2.80

Intervention (continued)

Perceived Degree to Which Intervention Efforts have Created Favorable Impacts on Student Populations Directly Receiving Services as Indicated by the Average Score of Intervention Project Directors (No. of Respondents = 47) on a Six Point Scale with 0 Lowest and 5 Highest

PERCEIVED IMPACTS OF INTERVENTION PROGRAM ON STUDENTS DIRECTLY RECEIVING SERVICES	TARGET POPULATIONS DIRECTLY SERVED BY INTERVENTION PROGRAM						
	1. AOD Users and/or Abusers	2. Concerned Persons	3. Recovering Students	4. Elementary Students	5. Middle School/ Junior High Students	6. Senior High Students	7. Total Student Population
a. Improved social functioning between students and peers	3.14	4.03	3.14	2.84	3.11	3.38	3.30
b. Improved relations between students and school staff	3.10	3.85	3.47	3.03	3.18	3.44	3.33
c. Improved relations between students and their families	2.80	3.20	3.33	2.66	2.89	3.08	3.05
d. Improved academic performance	2.95	3.37	3.36	2.66	2.76	2.95	2.97
e. Reduced alcohol use among students	2.88	3.13	3.56	1.96	2.71	3.05	2.97
f. Reduced marijuana use among students	2.95	2.97	3.79	1.96	2.54	3.25	3.03
g. Reduced cocaine or "crack" use among students	2.03	2.03	2.52	1.46	1.93	2.03	2.06
h. Decreased tobacco use among students	1.89	2.38	1.81	2.58	2.24	2.09	2.40
i. Reduced use of any other drugs among students	2.43	2.53	3.06	2.16	2.45	2.57	2.63
j. Improved physical health of students	2.67	3.00	3.41	2.45	2.86	3.00	2.89
k. Improved emotional/mental health of students	3.30	3.82	3.66	3.16	3.32	3.53	3.47
l. Reduced school dropout rates	2.55	2.95	3.23	2.12	2.26	3.00	2.84
m. Reduced contacts with law enforcement and courts	2.46	2.86	3.03	2.24	2.20	2.86	2.72
n. Reduced suicide attempts	2.68	2.91	3.38	2.19	2.53	3.06	2.88
o. Delayed onset of AOD use/abuse among students	2.19	3.09	2.16	3.30	3.03	2.64	2.84
p. Improved school attendance	2.78	3.30	3.36	2.50	2.68	3.13	3.08
q. Increased participation in "alternative" social and recreational activities	2.77	3.29	3.14	2.68	2.82	3.06	3.06
r. Increased identification of child abuse and neglect cases	2.13	2.92	2.44	2.50	2.60	2.40	2.47

Intervention (continued)

Degree to Which Factors Inhibit School Intervention Efforts as Indicated by the Average Score of Intervention Project Directors (No. of Respondents = 47) on a Six Point Scale with 0 Lowest and 5 Highest.

Inhibiting Factors	Degree to Which Factors Inhibit Intervention Efforts
a. Inadequate budget	2.77
b. Lack of coordination of school-based AOD intervention efforts	2.15
c. Lack of staff time for service delivery including screening, student contact, and group facilitation	3.43
d. Lack of staff time for planning and evaluation of AOD intervention efforts	3.15
e. Lack of administrative support	2.28
f. Lack of general staff support	2.30
g. Lack of parental support for school AOD intervention efforts	2.28
h. Lack of community support for school AOD intervention efforts	2.11
i. Lack of School Board support for AOD intervention efforts	1.98
j. High rate of alcohol use in the home	3.74
k. High rate of other drug use in the home	2.65
l. High rate of alcohol use in the community	3.89
m. High rate of other drug use in the community	2.60
n. Lack of involvement of local law enforcement personnel	2.38
o. Lack of involvement of juvenile justice system personnel	2.36
p. Lack of systematic coordination with school/community/business/industry programs and resources	2.47
q. Staff turnover	1.74
r. Lack of appropriate staff training	2.15
s. Active opposition of community interest groups against AOD intervention efforts	1.02
t. Community denial of problem related to AOD use	3.21
u. Student denial of problems related to AOD use	3.36
v. Parental denial of problems related to AOD use	3.40